

# Commentary

## Managed-Care Plans Their Future Under National Health Insurance

THOMAS P. WEIL, PhD, Asheville, North Carolina

The nation's health maintenance organizations, preferred-provider organizations, independent practice associations, and similar managed-care efforts are not well positioned to take a leadership role in a nationwide universal access or national health insurance plan. They—with the possible exception of some large staff and group health maintenance organizations—have been unable to show uniformly that they can contain costs, provide better access or higher quality of care, and achieve greater patient satisfaction than fee-for-service endeavors. As the United States pursues universal access as a step toward national health insurance, the managed-care plans will continue to increase their numbers of subscribers. They will not, however, be able to enroll large numbers of the young, low-income employees and their dependents who account for most of the 63 million people uninsured sometime during each year. Under national health insurance, there might be an option for some health maintenance organizations to negotiate capitated payments. The vast majority of the nation's physicians, however, will reluctantly embrace a centrally managed fee-for-service approach rather than a salary or capitated reimbursement method, leaving only a trace of the competitive managed-care plan theme in a future, primarily monolithic, national health care system.

(Weil TP: Managed-care plans—Their future under national health insurance. *West J Med* 1991 Nov; 155:533-537)

Access to needed services, high-quality patient care, value for the dollars expended, and patient satisfaction are considered major hallmarks of an effective managed-care plan. These are most popular in the West, where more than 55% of the employees who are insured through their employers are enrolled in health maintenance organizations (HMOs) or preferred-provider organizations (PPOs).<sup>1</sup> In fact, one proposed option for national health insurance is to have all payments made on a capitated basis to closed-panel plans like HMOs, which in turn would organize the delivery of health care services for their subscribers.<sup>2</sup>

Of the many changes that now affect our health care delivery system, perhaps none is of greater consequence than the “managed-care” revolution—the rapid growth during the 1980s of HMOs, PPOs, independent practice associations (IPAs), hybrid structures, and even fee-for-service approaches that include prospective utilization review and provider-selection standards. While this great diversity in the delivery of health care services provides a natural experiment to evaluate the efficacy of managed-care plans, universal access and national health insurance have become major domestic issues.

Recent opinion surveys indicate that nearly three out of four Americans are in favor of national health insurance,<sup>3</sup> and an increasing number of provider groups, including the American Medical Association<sup>4</sup> (AMA) and the Health Insurance Association of America (HIAA), favor universal access, if not universal insurance. The question therefore arises whether or not managed-care plans as we know them will play an increasingly important role in the future organization and financing of physicians' services that begins with universal access and leads eventually to a national health insurance plan.

### Managed Care—A Model for National Health Insurance?

The early advocates of prepaid group practice<sup>5</sup> had high expectations for the ability of managed-care or similar plans to contain costs, improve access, promote quality care, and ensure patient satisfaction—key elements in their long-term leadership role in a universal access or national health insurance plan.

#### *Utilization and Cost*

In an early study (1961-1974) of HMO versus fee-for-service performance, the managed-care plans provided a one-time cost saving by reducing hospital use.<sup>6</sup> The premiums for HMOs then rose on an annual basis just as rapidly as the fee-for-service plans. Later (1972-1982), when the effect of HMOs was compared with regulatory approaches in the nation's 25 largest standard metropolitan statistical areas (with controls for environmental conditions in each of these markets),<sup>7</sup> neither the managed-care-type competitive nor the regulatory model substantially reduced overall hospital costs.

Despite these early findings, it was expected that costs could be contained in regional or local medical care systems with a high percentage of HMO enrollees, such as Hawaii; Rochester, New York; and Minneapolis/St Paul, Minnesota. In none of the three sites studied, however, was there a demonstrable connection between reducing hospital use and HMO competition. Instead, reductions were “in each case attributable to other factors—including biases in data, long-term trends predating HMOs, indirect effects of policy changes, and other forms of competition.”<sup>8(p625)</sup> Competition from HMOs did not have the anticipated effects on hospitals until relatively recently as it neither directly addressed the

From the Bedford Health Associates, Asheville, North Carolina.

Reprint requests to Thomas P. Weil, PhD, President, Bedford Health Associates, BB&T Building, Suite 1019, Asheville, NC 28801.

#### ABBREVIATIONS USED IN TEXT

AMA = American Medical Association  
 HIAA = Health Insurance Association of America  
 HMO = health maintenance organization  
 IPA = independent practice association  
 PPO = preferred-provider organization

payment issue for inpatient care nor encompassed the range of forces that increase competition and foster cost-consciousness in the medical care arena.<sup>9,10</sup>

Compared with similar fee-for-service practices, more recent studies indicate that HMOs organized as staff and group practices have successfully reduced the rate of hospital admissions and the overall expenditures for physician services by 30% to 40% and for hospital services by 10% to 40%.<sup>11,12</sup> To attain these utilization and cost reductions, however, physicians have generally been paid on a salary or capitated basis and hospitals have been encouraged to accept lower reimbursement to ensure increased market share. In contrast, IPAs or foundations for medical care that pay independent physicians on a fee-for-service basis have not proved to be less expensive than pure fee-for-service practices, having traded lower inpatient for higher ambulatory use rates.<sup>13-15</sup> The overall impression is that staff and group HMOs might provide high-quality, lower-cost care than IPAs or fee-for-service plans. Additional longitudinal studies are needed, however, to compare matched patient populations and to evaluate patient satisfaction and the quality of care provided with the decreased hospital use patterns often noted in HMOs.

#### *Access to Care*

To contain utilization and ensure operating surpluses, both traditional fee-for-service and managed-care plans practice patient skimming, or the selective enrollment of only healthy groups or persons.<sup>16-20</sup> A possible problem is that managed-care plans might refuse to enroll those high-risk, high-cost uninsured persons who could clinically and fiscally profit the most.

Another way in which HMOs reduce access to care is by fostering the likelihood that unethical behavior on the part of physicians could increase when there is no trusted and impartial "gatekeeper" acting on behalf of patients.<sup>21</sup> Of the HMOs in one survey, 40% required primary physicians to cover outpatient laboratory costs out of their capitated payments.<sup>22</sup> Some plans pay primary physicians at the end of each year as much as 50% of the unspent funds allocated to hospital care, thereby providing a strong incentive to avoid inpatient use. Bodenheimer concluded that

this type of direct personal financial incentive—in which payment for the basic referral tools of the primary physician is deducted from that physician's own income—has great potential for abuse by underdiagnosis and undertreatment.<sup>23</sup>

#### *Quality of Care*

Although physicians have traditionally focused on high-quality patient care, given the incentive for undertreatment with HMOs, is there any detectable difference in the quality of care provided by fee-for-service practices compared with capitated plans? Although HMOs have been criticized for expending insufficient resources on preventive services and providing inadequate access to care (particularly to lower-

income patients), there is evidence that established HMOs deserve high marks on the overall quality of care rendered.<sup>24,25</sup> One of the difficulties in generalizing about the quality of care provided by managed-care plans is that the values and performance of the respected capitated plans differ greatly from some of the for-profit Medicaid and Medicare HMOs, for example, that sprang up particularly in California and Florida during the 1970s and 1980s.

#### *Patient Satisfaction*

Enrollees are generally highly satisfied with PPOs but less pleased with HMOs.<sup>26</sup> They tend to rate physicians' competence and willingness to discuss problems lower among HMOs than those in fee-for-service plans. It has not been determined whether this perception reflects real differences in competence rather than the amount of time physicians spend with their patients. The interpersonal aspects of the physician-patient encounter may suffer in a managed-care setting because of time pressures, without diminishing either the quality or the outcome of treatment.

In brief, the earlier enthusiasm for HMOs is waning, as shown by the current slowed growth in enrollment. The early financial statements of most plans showed that they needed to select more desirable risks, further cut utilization, or reduce the cost per unit of service, strategies that could then adversely affect their public image and the quality of care provided. Consumers who place a high priority on a free choice of provider and who will only choose an HMO if it is to their distinct fiscal advantage may limit increases in HMO enrollment.

If managed-care plans were the answer to the nation's health care problems relating to costs, access to care, quality, and patient satisfaction, HMOs would already have been mandated by at least one highly regulated state; in fact, these plans to date have fallen short of the results anticipated by some of their early advocates. This then leads to the question: Will managed-care plans have a major role in either universal access or a national health insurance plan?

#### *Universal Access as the First Step*

There are almost insurmountable problems to resolve and many compromises to be struck, but universal access will be enacted in more states soon and then nationally. This is largely because the continued rationing of care on the basis of a patient's insurance coverage or ability to pay is no longer acceptable to an increasing number of Americans.

There are several reasons why universal access appeals to elected officials, key provider groups, business leaders, and the uninsured.<sup>27</sup> First, even though it is likely that those previously uninsured will receive only limited physician and hospital benefits, universal access can be packaged by public officials as a monumental step toward meeting the nation's current health care crisis. Second, a universal access plan can be so designed that it gains the support of managed-care plans and other providers by allaying the fear of a monolithic—that is, all-government—system of funding and control. A universal access bill could be so designed that there would be relatively few changes in the current pluralistic delivery of health care services.

Third, with a pluralistic financing and administrative approach, there is a reasonable chance that a higher percentage of the nation's gross national product will be spent for health care services, giving managed-care plans and other providers

a larger pool of dollars. Fourth, as a result of state, federal, and private sector fiscal constraints, the extent of the basic benefits mandated for the uninsured will, in all likelihood, fall short of the more comprehensive coverage considered necessary. The managed-care plans could then opt not to seek new enrollees or selectively enroll additional subscribers, many of whom would be young, low-income wage earners and their dependents. Finally, and possibly more critical at this time, private and public sources will be more willing to share the additional costs of a universal access plan to meet a now well-publicized social need because they perceive it to be more affordable than national health insurance.

With mandated universal access and a projected increase in total health care dollars available, those managed-care plans that have proved most effective in controlling utilization and cost per unit of service and have a reputation for high-quality care for the premium expended will continue to prosper. Can these plans expect the same outcome under national health insurance?

### National Health Insurance as the Second Step

Universal access, for the reasons just detailed, will be a major step (following Medicare, Medicaid, and others) toward a national health insurance plan. Some of the same problems, however, that plague managed-care plans could cause this approach to fail under a more regulated, bureaucratic environment.

#### Eligibility

Under universal access, an average of 33 million—or, at a given point during the year, as many as 63 million—additional Americans would need to be provided with some basic physician and hospital benefits. This large, heterogeneous, newly insured population will be primarily young, low-wage earners who frequently exhibit transitory employment and dependency relationship patterns. This suggests that universal access could fail because of a built-in difficulty in defining eligibility and determining which of the three major potential sources of health care benefits—the employer's coverage, the state-subsidized health insurance risk pool,<sup>28</sup> or the expanded state Medicaid program—should bear the costs.

Under universal access, the managed-care plans might be able to increase the number of enrollees by only 3 to 4 million subscribers (say, 10% of those currently uninsured) because most HMOs are not set up to meet the needs of Medicaid recipients or those covered by state risk pools.<sup>29</sup> Moreover, few employers in service industries (excluding those related to health care), in retail sales, and in agriculture—which account for most of the uninsured—will be able to afford to offer HMO coverage. Rather than 1,500 or more competing companies nationwide providing health insurance coverage, or enrolling members and then constantly changing insurer or arguing with a carrier about which benefits are covered, many people would simply prefer being eligible for a card that guarantees universal access and compulsory health insurance benefits to every member of the family. The rationale for not enacting national health insurance now or for the past half century is documented extensively elsewhere.<sup>2,30-33</sup>

#### Benefits

To keep universal access affordable and ensure that it does not compete with existing health insurance contracts,

basic physician and hospital benefits will be limited. In fact, for managed-care plans to enroll many of the currently uninsured, they might organize coverage for most of these new subscribers through low-cost, low-overhead "Medicaid mills." The result could well be rationing, patient dissatisfaction, low quality of care, forced disenrollment of high-cost patients, and a deteriorating public image for HMOs.

If the nation's 25-year-old Medicaid program and the state risk pools are any example, universal access will fail because it will not be able to provide the 33 million persons who were previously uninsured the care they thought had been promised to them, thereby setting the stage for the passage (on an incremental basis) of national health insurance. With the potential for more broadly mandated benefits, the managed-care plans are in a better position to provide the comprehensive benefits envisioned under national health insurance, rather than universal access with its limited physician and hospital benefits.

#### Containing Costs

Although managed-care plans may not have had sufficient time to demonstrate cost-containing capabilities, their performance to date suggests that competitive market forces cannot contain the nation's future health care expenditures. The Medicare prospective payment system and the diagnosis-related groups, which have been described as a "pure type of regulatory intervention, despite its being occasionally clothed in market rhetoric,"<sup>34</sup> are the major successes of the competitive ideology of the Reagan-Bush era.

On a larger scale, in the AMA, HIAA, and some of the other universal access proposals, approaches like the current pluralistic system (multiple versus single payer), no mandatory assignment (acceptance of the assigned fee as total payment), and cost shifting from the public to the private sectors could remain the nation's predominant reimbursement methods. These issues are central to any discussion of the probable fiscal failure of universal access and the implementation of any national health insurance program.

American health care has evolved into a complex prepayment system of multiple organizations, not-for-profit and commercial carriers competing for enrollees, and various public programs covering the more onerous risks. A national health insurance plan could choose to mandate premium payments to HMOs and other carriers, thereby keeping the current multiple-payer system intact and able to continue with current administrative costs. An alternative is a single payer of health care costs at the state or federal level. Such a payer would collect taxes, Social Security contributions, and employer-employee premiums in one fund and use these monies to pay health care professionals through newly established state health services commissions.

The perceived difficulty in financing universal access without universal insurance is related at least in part to the experience that the United States, with multiple payers of health care and allowable extra billing, has suffered a relentless rise in health care costs. By comparison, Canada, with a single payer and thus no possibility of cost shifting and with mandatory assignment, has had more success controlling costs while providing universal access to care.<sup>34(p571)</sup> Japan, Great Britain, and other Western European countries have done much the same.<sup>23</sup> In these nations, the overall quality of care, as shown in gross measures of health status, equals or exceeds that of the United States. Moreover, France, West

Germany, and the Netherlands, with health care systems that more closely approximate the single-payer approach, have also been better able to control costs without adversely affecting quality of care.

On a more specific level, the new resource-based relative-value-scale Medicare fee schedule (being phased in over a five-year period starting in 1992) will be under attack by hospital-based physicians and many medical and surgical subspecialists, even though it will initially have only modest adverse effects on most of their incomes. Under national health insurance, it is unlikely that physicians would be paid an annual salary adjusted for specialty, experience, location, and other factors or on a capitated basis such as the one used by the British National Health Service. As a result, the Medicare relative-value or resource-based approach would become a critical historical precedent because it will be the linchpin in the reimbursement method with universal access and, later, universal insurance.

Under these circumstances, for physicians to support a national health insurance plan, they will have to be reimbursed under a universal and comprehensive public program according to a fee-for-service schedule. The fee schedule would be based on the then-existing Medicare and modified and expanded relative-value units, negotiated periodically between professional associations and state health services commissions. In the early years under national health insurance, physicians will probably be allowed to bill for extras, but this provision will be eliminated, once the universal insurance principle has been firmly established, to reduce the nation's overall health care expenditures and to portray a more egalitarian image for the plan.

A possible option available to then-existing managed-care plans would be to negotiate capitated rates with the state health services commissions. Under national health insurance, can managed-care plans provide comprehensive care at lower cost to patients or the state agency? Can HMOs provide higher quality than fee-for-service care? Can the HMOs provide the sort of patient-physician relationship that would enable this form of organization to become the dominant pattern across the nation? The evidence presented earlier suggests that large staff and group HMOs, which for the most part are also highly capitalized and leveraged, might have difficulty in successfully negotiating agreements with state health services commissions. Also, it is difficult to imagine that physicians with few of their patients eligible for HMOs, PPOs, IPAs, or similar arrangements will choose a capitated payment when fee-for-service is the prevailing payment method. This could well signal the death knell for almost all managed-care organizations under national health insurance.

### *Administering the Programs*

As the dialogue about universal access and national health insurance continues, the Woolhandler-Himmelstein estimate of a \$62-billion (1989) savings by virtue of a monolithic rather than pluralistic administration of a health insurance plan will attract much more interest.<sup>35</sup> As we look toward the possible implementation of a plan of universal access without compulsory insurance, we can also expect the probable establishment of new state health services commissions to administer Medicaid, risk pools for the uninsured, and other related functions. There is the obvious concern about federal and state governments' abilities to recruit staffs of qualified public servants who will be able to engender the level of trust

among physicians, hospitals, and other providers needed to effectively and efficiently implement universal access and, eventually, compulsory health insurance.

Most managed-care plans to date have been unable to uniformly show that they can contain costs, provide better access, provide better health care, and ensure more patient satisfaction than fee-for-service arrangements. As a result, they are not particularly attractive candidates for long-term leadership roles in a universal access or national health insurance plan. Moreover, managed-care plans are not well positioned to deliver care to the approximately 30 million young, low-wage earners and their dependents who will have basic physician and hospital benefits under a new universal access plan. Later, when a national health insurance plan is enacted with a fee-for-service payment plan as the predominant pattern, physicians will embrace that rather than reimbursement on a capitated basis. Based on the history of their inability to contain costs in a procompetitive era and the uncomfortable conceptual fit with the far more regulatory and bureaucratic approach under national health insurance, it is difficult to imagine that more than a few of the existing managed-care plans will play a key role in providing health care services in the next century.

### REFERENCES

1. Gabel J, DiCarlo S, Sullivan C, Rice T: Employer-sponsored health insurance. *Health Aff (Millwood)* 1990; 9:164
2. Enthoven A, Kronick R: A consumer-choice health plan for the 1990s: Universal health insurance in a system designed to promote quality and economy. *N Engl J Med* 1989; 320:29-37, 94-101
3. Blendon RJ, Donelan K: The public and the emerging debate over national health insurance. *N Engl J Med* 1990; 323:208-212
4. Todd JS: It is time for universal access, not universal insurance. *N Engl J Med* 1989; 321:46-47
5. Rorem CR: *Private Group Clinics: The Administrative and Economic Aspects of Group Medical Practice*. Chicago, Ill, University of Chicago Press, 1931
6. Luft H: How do health-maintenance organizations achieve their savings? *N Engl J Med* 1978; 298:1336-1343
7. McLaughlin CG: HMO growth and hospital expenses and use: A simultaneous-equation approach. *Health Serv Res* 1987; 22:183-205
8. Luft HS, Maerki SC, Trauner JB: The competitive effects of health maintenance organizations: Another look at the evidence from Hawaii, Rochester, and Minneapolis/St Paul. *J Health Polit Policy Law* 1986; 10:625-658
9. Johnson AN, Aquilina D: The impact of health maintenance organizations and competition on hospitals in Minneapolis/St Paul. *J Health Polit Policy Law* 1986; 10:659-674
10. Feldman R, Dowd B, McCann D, Johnson A: The competitive impact of health maintenance organizations on hospital finances: An exploratory study. *J Health Polit Policy Law* 1986; 10:675-697
11. Manning W, Liebowitz G, Goldberg GA, et al: A controlled trial of the effect of a prepaid group practice on the use of services. *N Engl J Med* 1984; 310:1505-1510
12. Hornbrook M, Berki S: Practice mode and payment method. *Med Care* 1985; 23:484-511
13. Holahan J: Foundations for medical care: An empirical investigation of the delivery of health services to a Medicaid population. *Inquiry* 1977; 14:352-368
14. Burkett G: Variations in physician utilization patterns in a capitation payment IPA-HMO. *Med Care* 1982; 20:1128-1139
15. Wagner E, Bledsoe T: The Rand health insurance experiment and HMOs. *Med Care* 1990; 28:191-200
16. Langwell K, Rossiter L, Brown R, Nelson L, Nelson S, Berman K: Early experience of health maintenance organizations under Medicare competition demonstrations. *Health Care Financ Rev* 1987; 8:37-55
17. Luft HS, Miller RH: Patient selection in a competitive health care system. *Health Aff (Millwood)* 1988; 7:97-119
18. Wilensky GR, Rossiter LF: Patient self-selection in HMO's. *Health Aff (Millwood)* 1986; 5:66-80
19. Langwell KM, Hadley JP: Insights from the Medicare HMO demonstrations. *Health Aff (Millwood)* 1990; 9:74-84
20. Rossiter LF, Langwell K: Medicare's two systems for paying providers. *Health Aff (Millwood)* 1988; 7:120-132
21. Luft HS: HMOs and the quality of care. *Inquiry* 1988; 25:147-156
22. Hillman AL: Financial incentives for physicians in HMOs: Is there a conflict of interest? *N Engl J Med* 1987; 317:1743-1748
23. Bodenheimer TS: Payment mechanisms under a national health program. *Med Care Rev* 1989; 46:27-28
24. Davies AR, Ware JE Jr, Brook RH, Peterson JR, Newhouse JP: Consumer

acceptance of prepaid and fee-for-service medical care: Results from a randomized controlled trial. *Health Serv Res* 1986; 21:429-452

25. Ware JE Jr, Brook RH, Rogers WH, et al: Comparison of health outcomes at a health maintenance organisation with those of fee-for-service care. *Lancet* 1986; 1:1017-1022

26. Rice T, Gabel J, de Lissovoy G: PPOs: The employer perspective. *J Health Polit Policy Law* 1989; 14:367-382

27. Brown LD: The medically uninsured: Problems, policies, and politics. *J Health Polit Policy Law* 1990; 15:413-426

28. Laudicina SS: State health risk pools: Insuring the 'uninsurable.' *Health Aff (Millwood)* 1988; 7:97-104

29. Anderson MD, Fox PD: Lessons learned from Medicaid managed care. *Health Aff (Millwood)* 1987; 6:71-86

30. Starr P: Transformation in defeat: The changing objectives of national health insurance, 1915-1980. *Am J Public Health* 1982; 72:78-88

31. Enthoven AC: Reflections on the Management of the National Health Service. London, Nuffield Provincial Hospital Trust, 1985

32. Butler S, Haislmaier E (Eds): *A National Health System for America*. Washington, DC, Heritage Foundation, 1989

33. Kinzer DM: Universal entitlement to health care: Can we get there from here? *N Engl J Med* 1990; 322:467-470

34. Evans RG, Lomas J, Barer ML, et al: Controlling health expenditures—The Canadian reality. *N Engl J Med* 1989; 320:571-577

35. Woolhandler S, Himmelstein DU: A national health program: Northern light at the end of the tunnel. *JAMA* 1989; 262:2136-2137

## DOCTOR'S WIFE

Feeling her bones  
the way he does  
helps him to do his job,  
and he says so frankly  
because he knows you know  
it's up to him to write  
the story of other women's lives.

He can talk for hours  
about veins and arteries  
and you listen,  
remembering it's his profession  
and not to be taken personally,  
that each night his hands,  
busy as ever,

will prove  
that loving you  
is what he has been doing  
all day long.

CONSTANCE PULTZ®  
*Charleston, South Carolina*